TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Faris Fakhoury, M.D.

Respondent Name
Poly America LP

MFDR Tracking Number
M4-15-1045-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
November 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[The injured employee's] symptoms did worsen after his visit with Dr Fakhoury on 9-23-14, and he presented to Wellington Regional Medical Center on 9-24-14. Dr. Fakhourys re-consulted him on 9-25-14 and Emergent/Urgent decision for surgery was determined."

Amount in Dispute: $34,546.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical documentation does not meet the definition of 'medical emergency' as defined by Rule 133.2. Therefore, the medical documentation does not support that emergency surgery was indicated. Preauthorization should have been obtained prior to the surgery. Thus, the Carrier is not liable for reimbursement associated with the non-preauthorized surgery."

Response Submitted by: Ayers and Ayers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2014	Evaluation & Management, new patient (99205)	$1,200.00	$31.35
September 23, 2014	Evaluation & Management, established patient (99214)	$575.00	$15.58
September 25, 2014	Initial Hospital Care, per day (99223-57)	$1,040.00	$334.59
September 26, 2014	Surgery (63271)	$12,376.00	$4,804.31
September 26, 2014	Surgery (22610-59)	$7,300.00	$1,420.15
September 26, 2014	Surgery (22842-59)	$4,500.00	$1,749.76
September 26, 2014	Surgery (22614-59 x 2)	$4,650.00	$2,165.98
September 26, 2014	Surgery (20930-59)	$700.00	$0.00
September 26, 2014	Surgery (69990-59)	$1,305.00	$0.00
September 26, 2014	Surgery (20936-59)	$700.00	$0.00
September 26, 2014	Fluoroscopic Guidance (77003-26)	$200.00	$49.89
		Total Due	**$10,571.61**

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 provides definitions for terms relevant to medical billing.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §134.600 sets out the requirements for preauthorization of services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer
   - 197 – Pre-authorization/authorization/notification absent
   - 198 – Pre-authorization exceeded

Issues

1. Are there unresolved medical necessity issues for procedure code 99214, date of service September 23, 2014?
2. Did Poly America LP maintain its denial of payment for procedure code 99205, date of service August 29, 2014?
3. Did services in dispute require preauthorization?
4. What is the maximum allowable reimbursement (MAR) for the disputed services?
5. Is Faris Fakhoury, M.D. entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.305(b) requires that medical necessity disputes be resolved prior to the submission of a medical fee dispute for the same services. Poly America LP denied procedure code 99214 for date of service September 23, 2014 with claim adjustment reason code 50 – "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

   Review of submitted documentation finds that Poly America LP did not maintain this denial, making a partial payment of $160.18 on February 6, 2015. Therefore, the division concludes that an unresolved medical necessity denial does not exist for this service. Because Dr. Fakhoury is seeking a total payment of $575.00 for this service, reimbursement will be evaluated in accordance with applicable fee guidelines.

2. Dr. Fakhoury is seeking reimbursement of $1,200.00 for procedure code 99205 for date of service August 29, 2014. Review of the submitted documentation finds no explanation of benefits submitted to Dr. Fakhoury prior to the request for medical fee dispute resolution.

   In its response, Ayers and Ayers stated on behalf of Poly America LP that "The Carrier issued payments in the amount of $308.56 for the August 29, 2014 date of service…" An explanation of benefits dated February 6, 2015 submitted with the carrier's response confirmed this amount paid. The division concludes that denial of payment for this service was not maintained. This reimbursement will be evaluated in accordance with applicable fee guidelines.

3. Poly America LP denied the services in question for dates of service September 25 and 26, 2014, with claim adjustment reason codes 197 – "Pre-authorization/authorization/notification absent," and 198 – "Pre-authorization/authorization exceeded." Dr. Fakhoury argued that these services did not require preauthorization because an emergency existed at the time of treatment. 28 Texas Administrative Code §133.2(5)(A) defines a medical emergency as:

   > … the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
   > (i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part;

In its response, Ayers and Ayers argued on behalf of Poly America LP that because Dr. Fakhoury had previously recommended surgery, "it cannot be said that the surgery qualifies as an 'emergency.'"

28 Texas Administrative Code §134.600(c)(1)(A) states that the insurance carrier is liable for all reasonable and necessary medical costs relating to health care listed in subsections (p) and (q) when an emergency occurs, as defined in 28 Texas Administrative Code Chapter 133.

The division notes that, regardless of whether the health care had previously been discussed or recommended, Rule §134.600(c) does not require preauthorization when an emergency has occurred. The definition of emergency does not require that the patient actually *be* in jeopardy or *suffer* serious dysfunction. Rather, what is required is that the patient manifest acute *symptoms* of such severity (including severe pain) that the absence of immediate medical attention could *reasonably be expected* (prior to rendering services and *without the benefit of hindsight*) to result in serious jeopardy or dysfunction if treatment is not provided. The division therefore reviews the submitted information to determine whether an emergency situation is supported for the services in question.

Review of the submitted documentation finds that "the patient presented to the emergency department with worsening urinary and bowel incontinence associated with progressive weakness of the left lower extremity and worsening numbness in the right lower extremity with frequent falling episodes with inability to stand for extended periods without falling and inability to hold himself upright." Dr. Fakhoury determined to proceed by performing T7 with partial T6 and T8 laminectomies, thoracic intradural exploration with microdissection of adhesions and resection of arachnoid cyst/spinal cord decompression, and bilateral T7 to T9 posterolateral fusion, with intraoperative neurophysiologic monitoring.

The documentation submitted to the division supports that the injured employee experienced a sudden onset of acute symptoms that required immediate medical attention – the absence of which could have reasonably resulted in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction to the injured employee's body parts or organs. This meets the definition of a medical emergency.

As a medical emergency was supported at the time of admission, the service dates in question did not require pre-authorization. Rule §134.600(c)(1)(B) is not applicable to the services in question. The applicable rule is §134.600(c)(1)(A), which states that the carrier is liable because an emergency situation had occurred as defined in Chapter 133. As preauthorization was not required, the insurance carrier's denial codes are not supported.

4. 28 Texas Administrative Code §134.203(c) states,

> To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
> (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor. The division conversion factor for 2014 is $55.75 for Evaluation and Management services and $69.98 for surgery in a facility setting.

Procedure code 99205 performed in the billed location on August 29, 2014: The relative value (RVU) for work of 3.17 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 3.17. The practice

expense (PE) RVU of 2.35 multiplied by the PE GPCI of 1.041 is 2.44635. The malpractice (MP) RVU of 0.26 multiplied by the MP GPCI of 1.849 is 0.48074. The sum of 6.09709 is multiplied by the division conversion factor of $55.75 for a MAR of $339.91.

Procedure code 99214 performed in the billed location on September 23, 2014: The RVU for work of 1.50 multiplied by the GPCI for work of 1.000 is 1.50. The PE RVU of 1.41 multiplied by the PE GPCI of 1.041 is 1.46781. The MP RVU of 0.10 multiplied by the MP GPCI of 1.849 is 0.1849. The sum of 3.15271 is multiplied by the division conversion factor of $55.75 for a MAR of $175.76.

Procedure code 99223 performed in the billed location on September 25, 2014: The RVU for work of 3.86 multiplied by the GPCI for work of 1.000 is 3.86. The PE RVU of 1.56 multiplied by the PE GPCI of 1.041 is 1.62396. The MP RVU of 0.28 multiplied by the MP GPCI of 1.849 is 0.51772. The sum of 6.00168 is multiplied by the division conversion factor of $55.75 for a MAR of $334.59.

Procedure code 63271 performed in the billed location on September 26, 2014: The RVU for work of 29.92 multiplied by the GPCI for work of 1.000 is 29.92. The PE RVU of 19.25 multiplied by the PE GPCI of 1.041 is 20.03925. The MP RVU of 10.11 multiplied by the MP GPCI of 1.849 is 18.69339. The sum of 68.65264 is multiplied by the division conversion factor of $69.98 for a total of $4,804.31. Per Medicare policy, if this procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, the procedure with the highest fee schedule amount is reimbursed at 100 percent and subsequent procedures are reimbursed at 50 percent. Procedure code 22610 also has an indicator of 2. This procedure has the highest fee schedule amount. Therefore, the MAR for this service is $4,804.31.

Procedure code 22610 performed in the billed location on September 26, 2014: The RVU for work of 17.28 multiplied by the GPCI for work of 1.00 is 17.28. The PE RVU of 14.13 multiplied by the PE GPCI of 1.041 is 14.70933. The MP RVU of 4.65 multiplied by the MP GPCI of 1.849 is 8.59785. The sum of 40.58710 is multiplied by the division conversion factor of $69.98 for a total of $2,840.29. Per Medicare policy, if this procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, the procedure with the highest fee schedule amount is reimbursed at 100 percent and subsequent procedures are reimbursed at 50 percent. Procedure code 63271 also has an indicator of 2. This procedure does not have the highest fee schedule amount. Therefore, the MAR for this service is $1,420.15.

Procedure code 22842 performed in the billed location on September 26, 2014: The RVU for work of 12.56 multiplied by the GPCI for work of 1.000 is 12.56. The PE RVU of 6.11 multiplied by the PE GPCI of 1.041 is 6.36051. The MP RVU of 3.29 multiplied by the MP GPCI of 1.849 is 6.08321. The sum of 25.00372 is multiplied by the division conversion factor of $69.98 for a MAR of $1,749.76.

Procedure code 22614 performed in the billed location on September 26, 2014: The RVU for work of 6.43 multiplied by the GPCI for work of 1.000 is 6.43. The PE RVU of 3.13 multiplied by the PE GPCI of 1.041 is 3.25833. The MP RVU of 1.69 multiplied by the MP GPCI of 1.849 is 5.78737. The sum of 15.4757 is multiplied by the division conversion factor of $69.98 for a total of $1,082.99. The MAR for 2 units is $2,165.98.

Procedure code 22930 performed in the billed location on September 26, 2014: This procedure code has a status of “B,” which signifies that “payment for covered services are always bundled into payment for other services not specified.” Therefore, no reimbursement is recommended for this procedure code.

Procedure code 69990 performed in the billed location on September 26, 2014: Per CCI edits, procedure code 69990 is a component of procedure code 22610. Per CCI edits a modifier is not allowed to differentiate the service. No reimbursement is recommended for this procedure code.

Procedure code 20936 performed in the billed location on September 26, 2014: This procedure code has a status of “B,” which signifies that “payment for covered services are always bundled into payment for other services not specified.” Therefore, no reimbursement is recommended for this procedure code.

Procedure code 77003-26 performed in the billed location on September 26, 2014: The RVU for work of 0.60 multiplied by the GPCI for work of 1.000 is 0.60. The PE RVU of 0.23 multiplied by the PE GPCI of 1.041 is 0.239430. The MP RVU of 0.03 multiplied by the MP GPCI of 1.849 is 0.05547. The sum of 0.8949 is multiplied by the division conversion factor of $55.75 for a MAR of $49.89.

5. The total MAR for the disputed services is $11,040.35. The insurance carrier paid $468.74. An additional reimbursement of $10,571.61 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $10,571.61.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $10,571.61, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 29, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.